State of Missouri
Department of Mental Health
Division of Alcohol and Drug Abuse

CLINICAL UTILIZATION REVIEW REQUEST

Access to Recovery (ATR), Primary Recovery Plus (PR+,) Clinical Treatment Form

Instructions: Complete the form by filling in the blank or selecting the appropriate response. Fax the completed form to the clinical review unit at (573) 751-9296. A complete ASI report must be available on the Outcomes Web or via fax. 10-25-2005

Name of consumer DMH I.D. number DOB
Name of Agency Agency telephone number Agency fax number for reply
Contact Person to answer clinical review questions Title
Date of admission Drug of choice Date of last use
Consumer's initial level of care Consumer's current level of care
Has the consumer received other substance abuse treatment during the past two years?
If yes, please explain:
Is the consumer currently pregnant? _____

Detoxification Extension
Date Admitted to Detox Total number of days of substance use prior to admission
Describe these patterns of use: substance used, amount, social behavioral effects
Number of additional days of detoxification services anticipated
Which of the following has the consumer experienced? Please check all that apply.
☐ Extensive impairment or delay in stabilization of vital signs
☐ Co-occurring physical health problems
☐ Co-occurring mental health problems
☐ Other life crisis that affects physical and mental functioning
☐ Difficulty in performing daily tasks
Explain:

For a transfer to L1 or for an extension of Level 1 services complete the following:
Date admitted to Level 1 Number of additional days of L1 requested.
Does the consumer also require residential support? If yes, how many days?
If the consumer has already had residential support, how many days used?
Which of the following has the consumer experienced?
☐ The detoxification was more complicated or difficult than usual.
☐ The consumer was unusually resistant to treatment but has shown increased participation, motivation, and progress.
☐ An episode of alcohol or drug use occurred during the course of treatment.
☐ Issues not initially identified surfaced and required additional time to address.
☐ A co-occurring disorder or other medical issue required medication during L1 treatment and additional time for stabilization is needed.
Explain:

For a return to L2 or for an extension of L2 or L3 services, please complete the following:
Level requested Additional dollars needed
Explain reason for the request:

Notes or Comments